

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 20578
Registrar's No. 5390

Registration District No. 791 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G. Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days (Specify whether
In this community 45 yrs. years, months or days)

3. (a) PRINT FULL NAME Alice Fletcher

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Col. 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased January 12, 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 5 12 hr. min.

9. Birthplace Memphis Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER { 12. Name Jeff Stevens
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Mary ?
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Rosie Lee Stevens
(b) Address 1500 S. 3rd. St. 3rd. Fl.

17. (a) Burial (b) Date thereof 7-2-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director F.A. Green
(b) Address 2915 Franklin Avenue

JUN 30 1941 (Date received local registrar) J. W. Bredbeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 1500 S. 3rd. St. 3rd. Fl. (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25
year 1941 hour 1:20 minute _____ P. M.

21. I hereby certify that I attended the deceased from June 17 41 to June 25 41
that I last saw her alive on June 25 41
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration 16 days

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? (Specify type of place) _____ Means of injury _____

23. Signature Clarence Allen (M. D. or other) 6/25/41
Address 2601 N. Whittier Date signed _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

G. A. Jones

Licensed Embalmer No. *2963*

P. O. Address *2915 Franklin*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.